Low-Income and Uninsured:
The Challenge for Extending Coverage

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for

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Summary

- Today, over 40 million Americans are without health insurance. The uninsured are predominantly low-income working families—two-thirds (65%) of uninsured families have incomes below 200 percent of the poverty level (or less than $30,000 per year for a family of three today).

- Most are uninsured because they do not obtain coverage in the workplace. Eight in ten of the uninsured come from working families, but over 70 percent of all uninsured workers do not have access to job-based coverage. Low-wage workers are particularly disadvantaged—only 55 percent of low-wage workers earning $7 per hour or less are offered coverage compared to 96 percent of higher wage workers earning above $15 per hour.

- Although most workers participate in employer health plans when offered, affordability is a major issue. On average, employees contribute 26 percent of premium costs ($1,656 in 2000). For a full-time worker earning $7 per hour, the employee share of premiums represents over 10 percent of the family's annual $14,500 income.

- Medicaid assists many low-income families by providing health insurance coverage with limited cost-sharing and essential benefits to 21 million low-income children and 8 million parents. But Medicaid's reach for low-income adults is severely limited—income levels for parents in 33 states are below poverty and childless adults are generally excluded from coverage, no matter how poor.

- Health insurance matters for the millions of Americans who lack coverage—it influences when and whether they get necessary medical care, the financial burdens they face in obtaining care, and, ultimately, their health and health outcomes.

- As the experiences of Dianna Oden of Mosier, Oregon and Patricia Nelson of Louisville, Tennessee demonstrate, millions of low-income, hard-working families struggle every day to cope without coverage while their medical bills mount and their health suffers.

- Extending coverage to the millions of Americans without health insurance is both an important policy and health objective. For the low-income uninsured population, any effort to extend coverage must address the high cost of coverage faced by people with limited incomes and the lack of access to private health insurance for low-wage workers. The most immediate and potentially most effective means of broadening coverage is to build on the current public programs—Medicaid and CHIP—that have been designed to provide health coverage for low-income populations.

Statement of Diane Rowland, Sc.D.

Thank you for the opportunity to offer testimony at this hearing on "Living Without Insurance: Who's Uninsured and Why?" I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. The national, bi-partisan Commission serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform.

Despite a strong economy and sustained economic growth with historically low levels of unemployment, over 40 million Americans remain without health insurance today. Touching one in five people each year, the uninsured population is one predominantly of low-income, working Americans and their families. My testimony today will provide a profile of the low income uninsured population and discuss factors contributing to their lack of insurance and the importance of broadening coverage.

The Uninsured

Today, most Americans receive their health insurance coverage through an employer-sponsored health plan offered through the workplace, but for millions of working families, such coverage is either not offered or financially out-of-reach. Medicaid and the State Children's Health Insurance Program (CHIP) help fill in the gaps for some of the lowest income people, but this publicly sponsored coverage is directed primarily at children and varies across the states. As a result, 42 million Americans were without health insurance in 1999.

The majority of the nation's 42 million uninsured are low-income — individuals and families with incomes less than 200 percent of the poverty level. For a family of three in 2001, this is an annual income of less than $30,000. Nearly two-thirds of the uninsured (65%) came from family units with incomes at or below that level (Figure 1). Over a third of the uninsured (36%) come from families living below the poverty level.

Low-income adults are at greatest risk of being uninsured and comprise nearly three-quarters of the 27.5 million low-income uninsured (Figure 2). Low-income men have the greatest likelihood of being without insurance— 44 percent are uninsured compared to 36 percent of low-income women. Less than a quarter (24%) of low-income children are uninsured, largely due to the efforts to broaden coverage through Medicaid and CHIP.

The likelihood of being uninsured decreases substantially as income rises (Figure 3). Nearly four in ten (39%) of the poor and 29 percent of the near-poor are uninsured in contrast to 7 percent of people with incomes at or above three hundred percent of poverty, or roughly $40,000 for a family of three. Medicaid helps to offset the lower levels of private insurance for over a third (37%) of the poor and 16 percent of the near-poor. The near-poor run a high risk of being uninsured because with their higher incomes they are less likely to be eligible for Medicaid than the poor, but also less likely than higher income families to have access to employer sponsored health insurance.

Limits to Private Insurance for the Low-Income Population

One of the major factors contributing to the high proportion of uninsured people in the low-income population is that, unlike most Americans, they are not obtaining health insurance coverage through the workplace. Eight in ten of the uninsured come from working families. Most of the uninsured (71%) come from families where at least one person works full-time outside the home and another 12 percent come from families with part-time employment. Among the low-income uninsured, 59 percent of the poor and 96 percent of the near-poor are working or have workers in their families (Figure 4). Yet, despite their attachment to the workforce, these uninsured families are falling outside the reach of employer-sponsored coverage.

Over 70 percent of all uninsured workers, and consequently their families, are not offered job-based health coverage, either through their own or a family member's job. Lack of access to employer-sponsored coverage is particularly a problem for low-wage workers (Figure 5). Only 55 percent of low-wage workers (earning $7 per hour or less) have access to job based coverage through their own or a family member's job compared to 96 percent of high-wage workers. For 45 percent of low-wage workers, in contrast to only 4 percent of high-wage workers, health benefits were not offered.

The likelihood of being offered coverage in the workplace depends largely on where one works and the wage-level of the firm. Most large firms offer coverage, but many smaller firms do not (Figure 6). Small firms face particular challenges in offering their employees coverage due to high turnover rates and small risk pools, which often lead to high premiums for group coverage. However, 85 percent of small firms with

mostly high wage employees (less than a third of workers earning under $20,000 per year) offer coverage compared to only 35 percent of small firms with predominately low-wage workers. Low wage workers are more likely to work in these small businesses and retail and service jobs where health insurance is not offered as a fringe benefit.

When health insurance is offered in the workplace, most employees opt for coverage even though the share of the premium borne by the employee can be substantial, especially for low-wage workers. In 2000, the average family premium for employer sponsored group coverage was $6,348 (Figure 7). The worker's contribution to that premium was, on average, 26 percent, or $1,656 for the year. For a full-year, full-time worker earning $7 an hour, the employee share of premiums represents 11 percent of the family's $14,500 annual income.

If health insurance coverage is not available through a group policy from an employer, families are hard pressed to be able to find and pay for a policy in the individual insurance market. Most directly purchased policies are expensive and have more limited benefits and more out-of-pocket costs than group coverage plans. Moreover, the cost of these policies is based on age and health risk, and any preexisting health conditions are generally excluded from coverage. For the average low-income family, a $6,000 family policy in the individual market would consume a quarter or more of their income and provide only limited protection.

The limits of employer-sponsored and privately purchased health insurance leave millions of low-income children and adults at risk for being uninsured. While on average a third (34%) of non-elderly low-income people are without insurance today, uninsured

rates vary widely across the country, reflecting the economic environment and employment structure in different states. States with more agriculture and small business and retail industry and less manufacturing have higher rates of uninsurance. In 1999, 25 states had a third or more of their low-income population uninsured (Figure 8).

The Role of Medicaid

For 40 million low-income Americans, Medicaid provides an essential safety net to fill in gaps in private insurance and Medicare. For 21 million low-income children and 8 million low income parents, Medicaid provides health insurance coverage with limited cost-sharing and essential benefits. For 11 million elderly and disabled beneficiaries, Medicaid fills in Medicare's gaps, provides more extensive acute care services, such as prescription drugs, and covers long-term care.

Medicaid's role as an insurer for low-income families has evolved. Medicaid originated as a source of health insurance for the nation's welfare population—predominantly very poor children and single parents. Over time, its role has been expanded to include more poor and near-poor Americans. Federally mandated expansions in the 1980s and 1990s required states to cover all children under age 18 under poverty by 2002 and pregnant women and children under age six at slightly higher income levels. In addition, states were given discretion to extend coverage to these groups at higher income levels. Enactment of the State Children's Health Insurance Program (CHIP) in 1997 provided additional federal funding to states to

broaden coverage to children up to 200 percent of poverty, either through Medicaid or under a separate program.

Despite the impact of these expansions on coverage of children and pregnant women, the low-income population still has much higher rates of uninsurance than other income groups. Medicaid plays a strong role in reducing uninsured rates among children, where over half (53%) of poor children and a quarter (26%) of near poor children rely on Medicaid. However, while low-income women are more likely to have Medicaid coverage than low-income men, adults of both genders still have exceedingly high rates of uninsurance— 42 percent of poor women and 52 percent of poor men are uninsured (Figure 9).

High rates of uninsurance in these groups persist for two reasons: millions of low-income adults remain ineligible for coverage under Medicaid and many people who are eligible, especially children, are not enrolled. Parents of eligible children are often excluded because, in many states, these levels remained tied to the old income eligibility levels for welfare assistance (Figure 10), which are considerably lower than the minimum levels established for children. Moreover, low-income childless adults are not eligible for coverage no matter how poor, unless they qualify as disabled individuals. These limits, coupled with less than full participation among those who are eligible, leave millions of poor and near-poor Americans uninsured.

Coverage of children can be significantly improved by strengthening Medicaid's role as an insurer of low-income children. With the decoupling of Medicaid and welfare as part of welfare reform in 1996 and the enactment of CHIP in 1997, states have new

and broad opportunities to extend the reach of Medicaid and CHIP to millions of low-income uninsured children. Through Medicaid and CHIP, states have substantially expanded the income levels to provide assistance to poor and near-poor children. By 2000, 36 states had raised their income eligibility levels at or above 200 percent of poverty (Figure 11).

However, while all states have used these opportunities to raise eligibility levels for children, the program does not always work as well as it could to attract and enroll low-income children. Often, eligible children remain uninsured because their parents are not aware of the coverage available from Medicaid or find the hurdles to establish eligibility and enroll too cumbersome. Long application forms with extensive questions on work history, assets, and personal information, coupled with use of welfare offices and personnel for processing enrollment, have discouraged many applicants from initiating or completing the process. Moving to simplify enrollment and reduce the burden on families to apply is essential for Medicaid coverage to work effectively for low-income working families. Many states have already taken steps to make Medicaid coverage more accessible (Figure 12).

While much more progress can be made in improving how Medicaid works for children, Medicaid's current reach among low-income families is compromised by limitations in coverage of parents of eligible children. Medicaid originally covered low-income families by including both children and parents receiving welfare assistance. However, over time, as eligibility expansions focused on children and pregnant women, coverage of parents lagged behind, often remaining at state welfare levels. As a result,

millions of low-income children have gained eligibility while their parents, unless pregnant, remain uninsured. In addition, many parents who are eligible for Medicaid but not enrolled lost coverage in the wake of welfare reform, as confusion and computer systems problems erroneously dropped many from Medicaid coverage when they left cash assistance.

Nearly thirty percent of low-income adults with children are uninsured (Figure 13), and of these 5.3 million uninsured parents, less than one-third (31%) are potentially eligible for Medicaid but not enrolled. The bulk of uninsured parents (69%) do not currently qualify for Medicaid coverage because their limited income or assets make them ineligible under the stringent eligibility standards for adults. One of the key strategies for improving coverage of the low-income population is to raise parents' eligibility levels to those of their children to achieve coverage for the whole family and provide an additional incentive to parents to enroll their children.

While welfare reform contributed to increasing the number of low-income uninsured parents, the changes enacted along with the welfare legislation under Section 1931 of the Social Security Act also offered states new opportunities to substantially expand family coverage. States were granted greater flexibility in family composition rules and the counting of income and resources, enabling them to extend coverage to single- and two-parent households and more low-income, working parents. Using either this new authority or Section 1115 waivers from the Secretary of Health and Human Services, 18 states now provide some Medicaid coverage to parents up to and above

100 percent of the poverty level (Figure 14). However, in 14 states, coverage for parents remains at or below 50 percent of poverty.

The most glaring omission in Medicaid coverage, however, is the exclusion of coverage for low-income childless adults. Nearly half of the uninsured low-income population falls outside Medicaid's reach because they are adults without children. Low-income adults without children have the highest rates of lack of insurance— 48 percent of poor and 44 percent of near-poor childless adults are uninsured. Unless they become totally and permanently disabled and can qualify for disability assistance under the Supplemental Security Income cash assistance program, they are generally ineligible for Medicaid. Eight states have used Medicaid waivers to provide Medicaid to low-income childless adults, but coverage remains limited.

Clearly, Medicaid plays a crucial role as an insurer of low-income children and adults, but coverage for the low-income population remains limited by restrictive eligibility and policies and procedures that have carried over from Medicaid's welfare heritage. Converting Medicaid from a welfare assistance program to a health insurer for low-income people and building on Medicaid and CHIP offer an opportunity to bring broader-based coverage to the low-income population and fill the gaps left by employer-based coverage.

The Importance of Insurance

Health insurance makes a difference in when and if people get necessary medical care, where they get their care, and ultimately, how healthy people are.

Uninsured adults are far more likely than the insured to postpone or forgo health care altogether and less able to afford prescription drugs or follow through with recommended treatments (Figure 15). Because children are generally healthier than adults, problems getting needed care are less common, but disparities in access to care between uninsured and insured children are as great as the differences between adults. The consequences of reduced access to care can be severe, particularly when preventable or treatable conditions go undetected.

The uninsured are at least three to four times more likely than those with insurance to report problems getting needed medical care, even for serious conditions. Part of the reason many of the uninsured postpone or forgo needed care is because they have no usual source of care. Over a third of uninsured adults do not have a regular place to go when they are sick or need advice, compared to less than 10 percent of those with coverage. Anticipating high medical bills, many of the uninsured are not able to follow recommended treatment. Nearly a third of uninsured adults say they did not fill a drug prescription in the past year due to cost and more than a third went without a medical test or treatment that had been recommended. Insured nonelderly adults are at least 50 percent more likely to have had preventive care such as pap smears, mammograms, and prostate exams than uninsured adults.

Because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems. Conditions like diabetes and hypertension, for example, can usually be managed successfully outside the hospital. The uninsured are more than twice as likely to be hospitalized for

these two conditions as those who have health insurance. When they are hospitalized, the uninsured also have a greater chance of dying.

Not having access to preventive screening catches up with the uninsured in greater cancer severity. The uninsured have been shown to have a much greater chance of being diagnosed with late-stage breast, prostate, colorectal, and skin cancer than the insured. Late-stage cancer translates into higher mortality rates among the uninsured. For example, among uninsured women diagnosed with breast cancer, the uninsured are more likely to die from it, even after controlling for other health problems.

For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are twice as likely as those with health coverage to live in a household that is having difficulty paying monthly bills as basic as rent, food, and utilities. Medical bills can mount quickly for the uninsured, even for relatively minor problems like dental care, and the financial impact on a family can be serious.

Most of the uninsured do not receive health services for free or at reduced charge. Among families with at least one uninsured member, only a quarter report they have received this kind of charity care in the past year. The large majority of the uninsured are paying for care out-of-pocket and increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they either pay with credit cards (typically with high interest rates) or negotiate a payment schedule with the clinic or hospital. In the case of hospital bills, the debt may take years to repay.

Having health insurance makes a difference in the debt individuals and families face because of medical bills (Figure 16). The uninsured are more than twice as likely to have had problems paying medical bills in the past year as those who have coverage. In addition, the impact of these bills is much greater on uninsured families. Among the nearly 40 percent of uninsured adults who had problems paying medical bills in the last year, the majority said that this debt had a major impact on their families' lives. Like any bill, when medical bills are not paid or paid off too slowly, they are turned over to a collection agency, and a person's ability to get further credit is significantly limited. Nearly 40 percent of the uninsured report that they were contacted by a collection agency about unpaid medical bills in just the past year.

The Impact of Being Uninsured

Being without insurance is a struggle that millions of hard working families and their children face every day. They do not lack insurance because they do not want it or do not believe in insurance. Most of the uninsured have, in fact, tried to obtain coverage but could not find coverage for an affordable price. As a result, they cope without coverage while their medical bills mount and their health suffers.

The experience of Dianna Oden of Mosier, Oregon—a 52 year-old uninsured waitress—and Patricia Nelson of Louisville, Tennessee—an uninsured widow whose son has asthma—bring reality to the statistics and studies on the uninsured. Their experiences seeking health insurance, obtaining medical care, and coping with their medical bills clearly portray the problem of being uninsured and low-income. Exhibits 1 and 2 highlight their situations.

Working all her life in restaurants, Dianna Oden has never had health insurance available through her job. Her annual income from wages of $6.50 an hour plus tips puts her at 170% of the poverty level— too high to qualify for the Oregon Health Plan, but not nearly enough to pay for an individual health plan. She suffers from fibromyalgia, a chronic disease that causes daily pain and stiffness, migraines, sleeplessness, and frequent diarrhea. Yet, on her limited income, Dianna Oden often doesn't get the medical care or medications she needs. On her take-home pay of $821 a month, she has $88 left after paying basic bills and about $100 for medical expenses. A private insurance plan with a $500 deductible, 25% co-insurance, and no drug coverage would cost her $213 a month—a quarter of her take-home pay—and not help with her monthly medication costs.

Patricia Nelson struggles in a different way with her son's overwhelming medical needs and hospitalization costs. Her husband died of Lou Gehrig's disease at age 35. Eight years ago, during a period when they were uninsured, her son was hospitalized for a severe asthma attack, leaving them with a bill of $6,000. Paying this bill off by at least $25 a month, they still owe the hospital $1,700. More recently, Patricia tried to get health coverage, but at $4,260 per year, the cost would have consumed 16 percent of her income. Her own recent kidney infection, coupled with a diagnosis of Bell's Palsy for her son, has left her facing over $12,000 in medical bills and living on Social Security Survivor's benefits. She has enrolled her son in TennCare, but she remains uninsured because enrollment for adults is closed. Due to her medical expenses, she has recently filed for bankruptcy.

In every state, there are people like Dianna Oden and Patricia Nelson and her son— people for whom the promise of medical care's life-saving and life-improving applications cannot be fully realized. They can neither afford the medical care they need nor the health insurance that helps make medical care both accessible and affordable. For them, health insurance matters but remains out of reach.

The Next Steps

Extending coverage to the millions of Americans without health insurance is both an important policy and health objective. However, no single incremental approach to restructuring and broadening health insurance coverage is likely to address the diverse needs of the 42 million uninsured Americans. For the low-income uninsured population, any effort to extend coverage must address the high cost of coverage faced by people with limited incomes and the lack of access to employer-sponsored health insurance for low-wage workers. Given these issues, the most immediate and potentially most effective means of broadening coverage is to build on the current public programs— Medicaid and CHIP— that have been designed to provide health coverage for low-income populations.

Extending public coverage to more low-income Americans would provide a subsidy for the full cost of comprehensive insurance and minimize the out-of-pocket costs to low-income families. Building on coverage available today through Medicaid and CHIP would help close the gaps that currently exist when some family members are eligible and others are ineligible for coverage and low-income childless adults are excluded from coverage. This approach also has the advantage of building on an

existing administrative and financing structure in operation in all 50 states. States already have systems in place for eligibility determination and provider and plan participation and payment. Finally, both families and states have embraced recent efforts to extend health insurance through public programs and value the coverage that Medicaid and CHIP provide.

As the efforts already underway in many states demonstrate, Medicaid and CHIP offer an effective strategy for insuring more low-income people. Substantial progress can be made by continuing to improve current outreach and participation efforts and by extending the scope of Medicaid to reach more of the nearly 20 million low-income uninsured parents and childless adults. These improvements, coupled with efforts to maintain and extend employer coverage for low-wage workers, will help to improve coverage for the most vulnerable Americans.

Thank you for the opportunity to testify today. I welcome any questions.

Exhibit 1

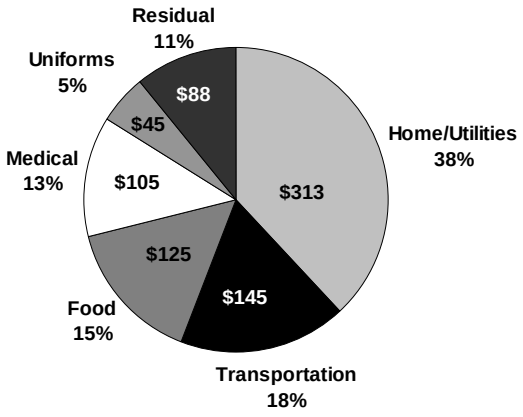
DIANNA ODEN

Dianna Oden is a 52 year-old single grandmother who works as a full-time waitress at a family restaurant near her home town of Mosier, Oregon. Working all her life in restaurants, either serving customers or in management, Dianna Oden has never had health insurance available through her job. Her annual income from wages of $6.50 an hour plus tips (with no paid vacation or sick days) puts her at about 170% of the federal poverty level — which is too high to qualify for the Oregon Health Plan, but not nearly enough to pay for an individual health plan.

Five years ago, Ms. Oden developed the symptoms of fibromyalgia, a chronic disease. With little discretionary income, she went to her doctor only when she was in a crisis, and because she came in so infrequently and with a different problem each time, he failed to see a pattern and treated the symptoms separately. Finally about a year ago, when her daily pain and stiffness, frequent diarrhea, migraines, and sleeplessness became overwhelming, she made an appointment to discuss them all. Only then did her doctor begin a thorough work-up to determine the cause of all her symptoms. The medication he has prescribed is effective, but unaffordable for her. Knowing this, Dianna's doctor gives her free samples whenever she comes in for an appointment, and she stretches these out by taking one pill every other day, instead of the prescribed daily dose. One time he was able to give her a full month's supply, which she described as giving her "a whole new lease on life". Encouraged by its effect, she finally filled the prescription for it, but was shocked to find that the drug would cost her $149 a month. She asked the pharmacist to give her $40 worth and she saves them for her worst days.

Despite all this, Dianna Oden is a hard worker and considers herself lucky. She has no debt, not even a mortgage or a car loan. However, after she pays her monthly bills for utilities, phone, transportation, groceries, and medical expenses, Dianna has $88 left from her take-home pay of $821. Living with fibromyalgia and paying over $100 a month in medical bills, Ms. Oden puts a high value on health insurance, but when she again checked into the cost of private insurance recently, she learned it would cost her $213 a month — roughly a quarter of her take-home pay — for a plan with a $500 deductible, 25 percent co-insurance, and no prescription drug coverage. Given the cost of even this limited health plan, she will probably remain uninsured for thirteen more years until she qualifies for Medicare at age 65.

Dianna Oden's Household Budget



Monthly Income: $821 Take Home Pay

Note: Annual gross income of $14,790 (170% of Federal Poverty Level)

Source: *In Their Own Words: The Uninsured Talk About Living Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured. September 2000.

Exhibit 2

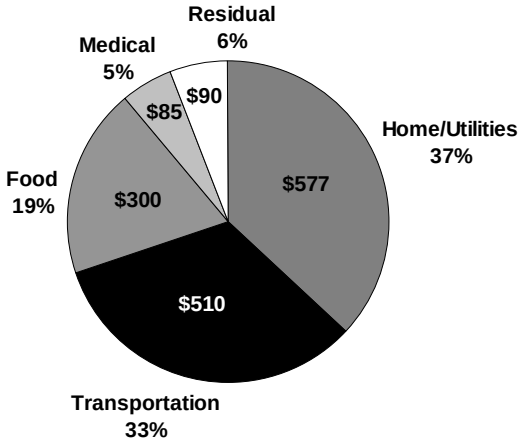
PATRICIA NELSON

Patricia Nelson, a 44 year old widow from Louisville, Tennessee, knows better than anyone what can happen if you are hospitalized without health insurance. Her husband lived with a disabling condition for many years before dying of Lou Gehrig's disease at the age of 35. Because of his disability, Medicaid, and later Medicare, covered his bills; however, Patricia and her 13 year-old son's health coverage has been spotty, depending on the job she held. She recalls a ten year period where she worked for the same restaurant, and as the ownership changed hands three times so did the offer of health benefits.

In one of the times the family was without health coverage, her son Sam, then five years old, suffered a bad asthma attack and needed to be admitted to the hospital. Two days in the hospital left them with a bill of $6,000. They checked on Sam's eligibility for Medicaid, and at that time, they missed the income eligibility cutoff by $4. Still paying off the bill by at least $25 a month, the balance after nearly eight years is $1,700.

Since we issued the report last fall, the Nelsons have faced even greater challenges. Patricia had recently taken a job in her sister's bakery. She looked into continuing her health coverage under COBRA, but at $4,260 a year it would have required 16% of her $27,000 income, and she didn't feel she could afford it. The family-run store lost its lease and went out of business this winter. While she was looking for work and living on only Social Security Survivor benefits, two medical crises hit. First, Patricia developed an undetermined infection that, after extensive tests, was isolated to her kidney. Then her son Sam woke one morning with facial paralysis and after a thorough neurological work-up was found to have Bell's Palsy. She now has him enrolled in TennCare. Facing over $12,000 in medical bills, Mrs. Nelson recently filed for bankruptcy.

Patricia Nelson and Her Son's Household Budget



Monthly Income: $1,562 in Social Security Survivor's Benefits

Note: Annual gross income of $18,744 (160% of Federal Poverty Level)

Source: *In Their Own Words: The Uninsured Talk About Living Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured. September 2000.